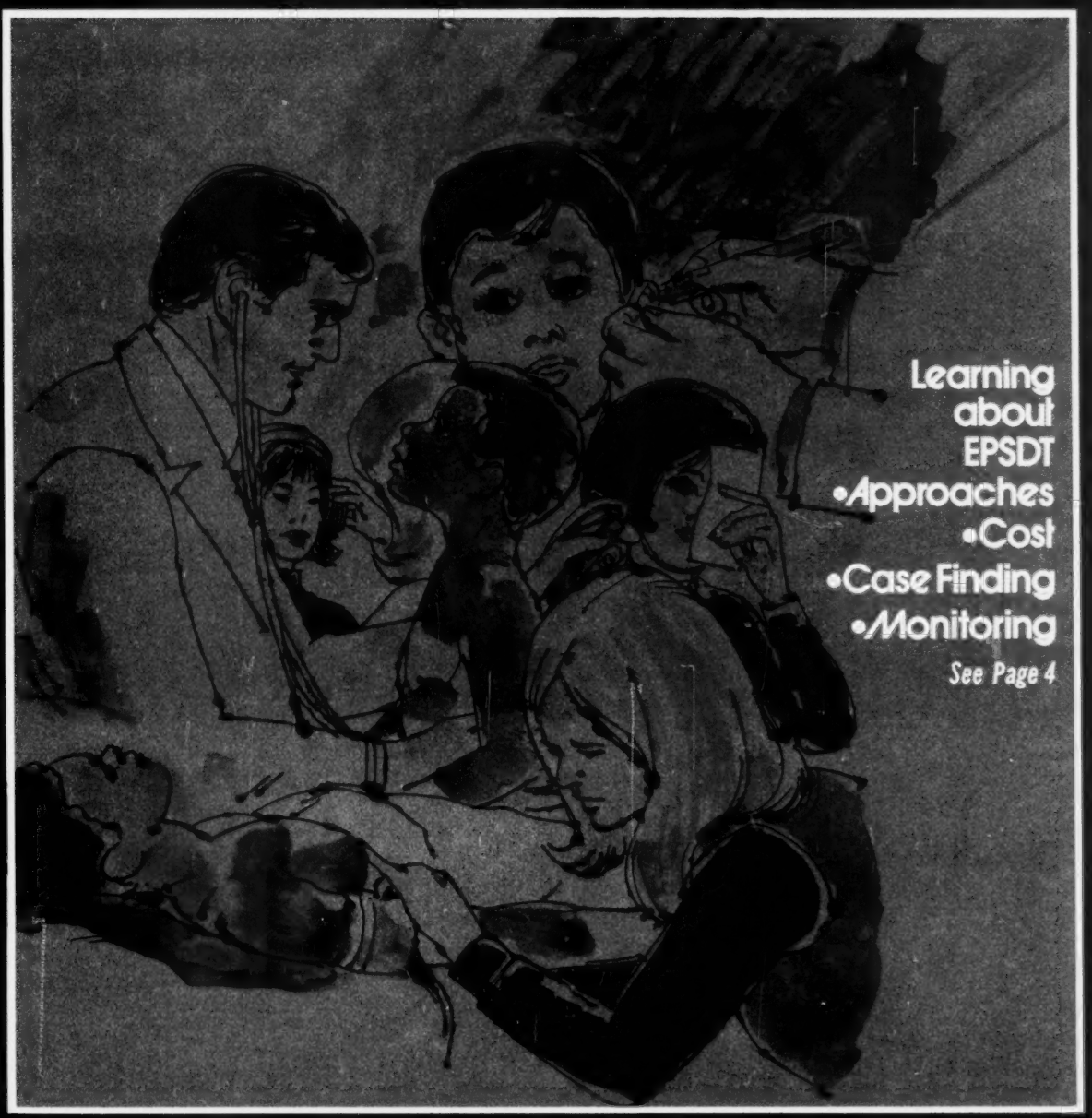
THE SOCIAL AND REHABILITATION

Record



Learning about EPSDT

- Approaches
- Cost
- Case Finding
- Monitoring

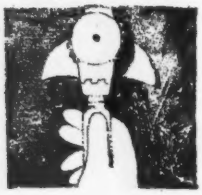
See Page 4

Social and Rehabilitation Service

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Volume 3, Number 1, April 1976

Children should be seen.



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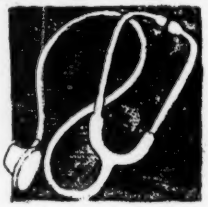

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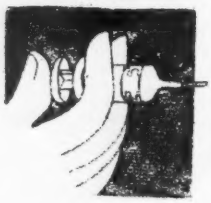

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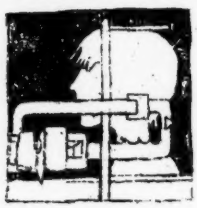

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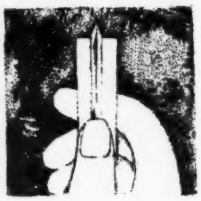

And charted.

And treated.

Preventive health services are important to vulnerable children . . . especially those from poor families, who have 3 times as much heart disease, 7 times the visual impairment, 6 times the hearing defects, and 5 times the mental illnesses. That's why there is an EPSDT program . . . Early and Periodic Screening, Diagnosis, & Treatment. Children in Medicaid families qualify for EPSDT.

For more information, see your local health or welfare office or write Commissioner, Medical Services Administration, Washington, D.C. 20201.

THE SOCIAL AND REHABILITATION
Record

With this issue, we open Volume 3 of THE SOCIAL AND REHABILITATION RECORD. We have had to skip the October, November, December-January, February, and March issues.

While we regret the irregularity in publication sequence, it was necessitated by organizational and program changes and severe personnel shortages. We have asked the Government Printing Office to automatically extend subscriptions five issues to make up for the missing ones. Ed.

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Medicaid Tries Prepaid Group Practice

Can Medicaid costs be reduced without lessening the quality of service?

This question was explored under a contract between the District of Columbia Medicaid program and Group Health Association, Inc., a prepaid group practice organization owned cooperatively by some 80,000 members. Subsequently, SRS made a grant to D.C. Medicaid for evaluation of the project and contracted with Westat, Inc., a private research organization, for an analysis.

The Medicaid program covers about 160,000 persons, or approximately 22 percent of the District's population.

One thousand Medicaid recipients were selected from a group of volunteers who agreed to obtain regular GHA services for a period of 3 years. The 1,000 persons represented a cross-section of the Medicaid population by sex, age, program category, and basis of eligibility. (In this article they will be referred to as the "GHA Study Group.") D.C. Medicaid paid half the cost of the premiums, the other half being paid with Federal funds under the regular State matching formula.

The GHA "benefit package" includes:

- Complete ambulatory care
- In-hospital care
- Skilled nursing home care
- Short-term psychiatric care
- Laboratory services
- Optical services (including eyeglasses)
- Drugs (legend and nonlegend)
- Podiatry
- Radiology
- Physical therapy
- Dental care
- Ambulance services

The D.C. Medicaid fee-for-service program provides all of these services except dental care and ambulance services.

The survey began in July 1971. The following main categories are compared:

1. Rates of utilization of services
2. Quality of medical care
3. Patient satisfaction
4. Costs of Medical care

Rates of utilization

Health services utilization by the GHA Study Group was compared for 12 months, 18 months, and 22 months, before and after enrollment in a prepaid group practice. Significant decreases in four categories of utilization—physician encounters, drug prescriptions, hospital admissions and hospital days—were reported for the age group 1 to 64 years. Ambulatory physician encounter rates decreased 15 percent, drug utilization was down 18 percent, hospital admissions decreased 30 percent, and hospital days declined 32 percent after enrollment in the prepaid group practice. But there was a remarkable increase in diagnostic services after enrollment.

Thus, it would appear that it is the *prepaid system* itself that *reduces utilization* and consequently reduces corresponding costs, assuming that the unit cost of a given service is the same in both systems, fee-for-service and prepaid.

Quality of medical care

Drug prescriptions were used as an indicator of the quality of care. In rates of prescriptions and costs of prescriptions, GHA was consistently lower. Prescription rates for the GHA Study Group were 10 percent lower than for the control group, indicating that GHA physicians prescribed fewer drugs generally. Incidentally, in both groups the rates were substantially higher for females

than for males (four per 1,000 for females vs. 1.6 per 1,000 for males); higher for NPA (population not on public assistance—medically indigent) than PA (population on public assistance—categorically indigent) clients (3.77 per 1,000 for NPA, 2.75 per 1,000 for PA).

No significant changes appear between GHA and fee-for-service doctors in range of drugs prescribed, antibiotics use, and prescription of generic designations. Overall per capita drug costs for 1972–1974 show:

Medicaid Group	1972	1973	1974
GHA Study Group	$23.55	$26.79	$28.45
Percent difference in favor of GHA	16.03	16.87	19.92
	32 %	37 %	30 %

Patient satisfaction

How well the two methods of obtaining health services met with the needs and desires of their clients was measured against such indexes as accessibility of care, out-of-plan utilization, out-of-pocket expenditures, and overall patient satisfaction with medical services received.

The results of the patient survey indicate that from the patient's point of view the care received from GHA was at least as satisfactory as that received through the regular Medicaid system.

A single GHA location was less convenient for the GHA Study Group patients. Only 7 percent of them were within walking distance, whereas the Medicaid control patients could choose their physicians on the basis of location, as well as other factors.

However, waiting time to appointment was less for the GHA Study Group. More than 80 percent waited less than a week, compared to only 63 percent for the Medicaid control group. Waiting time in the physician's office was also less for the GHA Study Group; more than 50 percent waited less than 10 minutes, compared to 10 percent for the control group.

Median out-of-pocket payment for services purchased by the Study Group was $8.60; for the control group, $17.00.

Summary results

Thus, in every major category, the costs for medical care for the GHA Study Group were lower—in some instances, substantially so—than for the Medicaid control group.

Medical costs generally have been increasing steadily during recent years. Hospital costs, for example, have risen between 5 and 10 percent annually.

Medicaid costs have increased from about $22 million in FY 1970 to $93 million in FY 1975—a four-fold jump. During the same period, the number of recipients of Medicaid benefits in D.C. doubled—from 66,251 to more than 141,000—and the cost per recipient increased two and one-half times—from $208 per year to nearly $500 per year.

Also, the cost per "annualized" person in Medicaid rose from $312 in calendar year 1970 to $456 in FY 1974.

In contrast, the cost per annualized person in the GHA Study Group decreased from $282 in 1972 to $232 in 1973.

A comparison between the GHA "benefit package"—the total annual services covered—and Medicaid fee-for-service costs between 1972 and 1974 shows:

Year	*GHA Study Group*	*Medicaid*
1972	$282	$373
1973	232	435
1974	286	465

The GHA cost is a 37-percent savings over Medicaid.

Thus, it is apparent that utilization of the D.C. Medicaid program can be reduced by substantial margins, with savings in costs through voluntary enrollment of Medicaid patients in prepaid group practices.

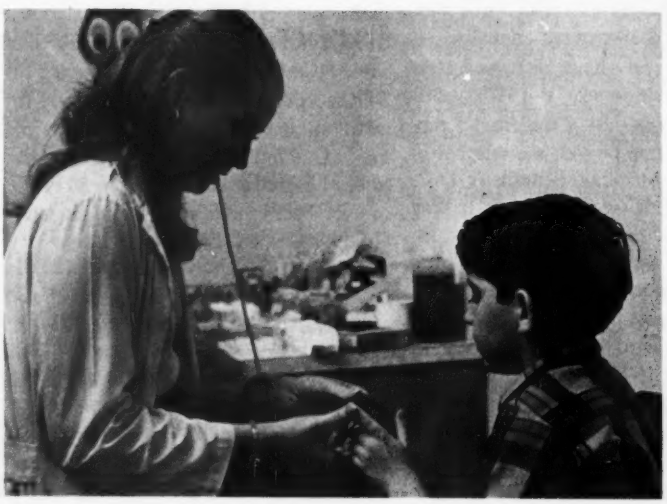
Reduced costs are also attributable to a diminution in hospital utilization by the GHA Study Group—from 1,002 acute hospital days per 1,000 persons per year for the Medicaid control group to an average of 687 days per 1,000 persons in the GHA Study Group. Since per diem costs in D.C. hospitals are about $150 a day, and both systems use the same hospitals, the savings amounted to $47,250 per 1,000 persons per year. In addition, while more than 50 cents of the D.C. Medicaid medical dollar goes to pay hospital costs, only 35 to 39 cents of every dollar paid for the GHA Study Group was spent for hospital costs.

This article is based on a five-volume study prepared by Westat Research, Inc. A one-volume summary will be published by HEW later in the year. Readers of THE RECORD will be informed of publication date. Participants in the article were Norman A. Fuller, Margaret W. Patera, and Krista Koziol.)

Demonstration Projects

Learning through Doing

HELEN MARTZ, PH.D.



Demonstration projects are a way of conducting experiments without commiting an agency or organization to a permanent staff and limitless activities. They permit an agency to examine and analyze hypotheses, theories, and conjectures without long-term commitment of money and staff.

SRS has been experimenting with methods of achieving a rounded health program, including prevention, comprehensive care, and continuity of treatment. The demonstration project is the vehicle we are using to explore new approaches, with opportunities to evaluate their effectiveness and practicability.

Its design is a cross between the traditional research project and the service delivery project; a hybrid which draws strength from each of the prototypes but with a uniqueness of its own geared to meet needs of emerging program components.

Demonstration projects under the SRS Section 1115 Demonstration Program relating to health care were initiated as early as 1971. They were directed to program components within Medicaid such as health maintenance organizations and alternatives to long-term care, and areas where changes were needed to strengthen the effective operation of existing programs. These included local organizational structure and staffing, reimbursement procedures, advance payments, case management, and provision of health-related supportive services. The results of these demonstrations have been used in program planning for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) component of the Medicaid program.

With the addition of significant new responsibilities under EPSDT for assuring that health care resources were available, accessible, and used effectively, attention since 1973 has been directed toward finding ways to help the Medicaid program adapt to these new responsibilities.

Four demonstration projects were initiated with a specific focus on EPDST. These projects were used as laboratories for identifying which components were essential to a comprehensive EPSDT program, and for experimenting with different approaches to administering EPSDT at the local level.

More recent projects were designed to get a more precise fix on the relative costs of specific components of EPSDT in these project settings, and a more precise assessment of the cost and benefit of alternative case finding and case monitoring techniques.

Several evaluation projects were directed toward developing information systems as a basis for assessing program activities. In addition, the Rural Health Demonstration Program provides for services directed to mothers and children, including EPSDT services.

Demonstration project planning for the coming year is being directed to additional EPSDT program areas needing exploration:

- inclusion of the older child in EPSDT—different ways of reaching the older child, substantive content of treatment plans, provisions for dealing with special problems of adolescence, and ways to enlist interest and support of voluntary organizations especially concerned with youth
- implementing the developmental assessment and treatment component of EPSDT—evaluating different testing modalities for identifying developmental lags, arranging for an interdisciplinary approach in identification, diagnosis and treatment of developmental lags, and enlisting interest and support of organizations, professional disciplines, and on-going programs dealing with handicapped children
- the role of the school in EPSDT implementation—coordination with existing school health programs and special programs for the handicapped, and training of supportive staff
- interagency collaboration in areas of mutual concern through joint project activity to learn how available resources can be used most effectively—e.g., Bureau of Education for the Handicapped, Health Nutrition and other relevant programs in the Office of Education; Developmental Disabilities; Office of Child Development; Maternal and Child Health and other programs within the Health Services Administration; research programs within the Health Services Research Center in the Health Resources Administration; National Institute of Mental Health, Housing and Urban Development, Supplementary Security Income, etc.

Preliminary findings of four EPSDT projects identified by the Health Services Research Institute in its evaluation of the projects indicate a great need for the services provided under the EPSDT program, as well as point up many of the problems in its implementation. For example:

- Less than 1 percent of the children screened had had a previous examination comparable to what is called for by EPSDT guidelines (92 percent in San Antonio, 85 percent in Contra Costa

County, and 64 percent in the District of Columbia projects had no physical examination in the past 12 months).

- Nearly half (47 percent) of the children screened were found to have medical problems, more than half (52 percent) medical and dental problems; 20 percent had two or more problems, and 7 percent had three or more problems.
- Sixty to 80 percent of the problems were previously unknown and untreated; 80 percent of these problems were chronic, and 20 percent acute.
- The most frequent problem found in screening was dental caries—25 to 50 percent of the children screened; iron deficiency was found in 13 percent, vision problems in 13 percent, and hearing loss in 9 percent.
- Immunization levels were low—45 to 80 percent of the children screened in three of the projects had no immunizations for DPT and polio. Missing records, absent parents and parents who did not know what their children had been immunized for contributed to difficulties in accurate reporting of immunizations.
- The high incidence of developmental lags was comparable to that generally found in the general population—in the D.C. project, 22 percent of 208 children screened were found to have a developmental lag, 40 percent of them had a lag in at least one of the following areas: language, cognition, visual, motor, and memory; in the Cuba project, 85 percent of 806 children screened had one or more problems in intellectual, visual, motor, emotional or language; 40 percent had two or more such problems, and 15 percent three or more; 45 percent of the problems were considered emotional, and 68 percent related to language problems; because of funding limitations, only those with three or more problems (15 percent) were scheduled for diagnostic evaluation.
- Many children with recognized problems were lost track of following referral to the provider; case monitoring is a major deficiency; referral is the weakest link.

- Paraprofessionals, with training and working under skilled supervision, were used successfully in case finding, case monitoring, health education, follow-up, and in assisting in physical and developmental history taking and some aspects of screening.
- Home visits by trained indigenous paraprofessionals is the most effective approach to case finding as measured by appointments scheduled and kept; (case finding efforts through letters and telephone calls were the least effective) and transportation when needed increased the effectiveness of this effort.
- Providing EPSDT services in day care and school settings have problems associated with synchronizing screening schedules with school activities, in obtaining needed information from parents, and in student absenteeism, but avoid other usual case finding problems.
- Increased focus on case management techniques stirred the interest of other community agencies.
- Costs per child screened averaged $30, medical diagnosis and treatment $35, and $20 for dental treatment (under near optimum conditions).
- Cost benefits were achieved in an earlier Portsmouth, Virginia, project through provision of comprehensive health services plus health-related supportive services to children, e.g., half as many visits to physicians, a third fewer days in the hospital, and a third less spent on drugs.

Preliminary findings from project evaluation suggested the need for program modifications, e.g.:

- Screening equivalents should be kept under rigid specifications; the results should be made available to the child's case monitor.
- The use of community aides, after training and working under skilled supervision, should be encouraged, and flexibility provided for convenient client hours; greater use of paraprofessionals and allied professionals can lower costs significantly, and extend services.
- Transportation services are essential, provisions for renting or purchasing vehicles and driver services are needed.
- The immunization status of each child screened should be reported; those with incomplete immunizations should be brought up to date at the screening site.
- Complete screening of each child should be accomplished on at least two visits; fragmented screening inflates screening costs.
- Due to the high incidence of dental caries, interagency effort should be directed to promoting programs of preventive dental health.
- Because of the high incidence of de-

velopmental lags, increased program emphasis is needed in determining the validity of testing instruments, in training and supervision of testers, in using the findings (in collaboration with parents and teachers) in arranging for diagnosis and follow-up treatment, and in developing needed treatment resources.

- There is also need for interagency collaboration with special education departments of schools, community health facilities, and other related community facilities to develop the resources needed for diagnosis and follow-through treatment for developmental lags.
- In providing or contracting for EPSDT services, provision in the budget should be made for case finding and case monitoring functions (under near optimum and comprehensive health care provisions within the projects, this averaged $22 for case finding, and $20 for case monitoring per child screened).
- Increased Federal funding is needed to assist States in carrying out case finding and case monitoring functions, and to reimburse States for diagnosis and treatment services since higher fees are needed to encourage greater provider participation.
- An adequate (usual) fee for dental care should be provided for the first visit, and a scale developed for determining a reasonable allowance for a treatment plan without prior authorization which, however, should be monitored periodically.
- Definitions for positive screening findings, and for reporting should be standardized; they are essential to effective program management.

The opportunity to learn through doing on demonstration projects, and the recommendations growing out of the data generated have already found their way into program modifications and new developments are now under way to strengthen the EPSDT program.

For example, increased Federal matching (up from 50 to 75 percent) is now available for local staff to provide health-related supportive services such as health education, case management, and related outreach activities. The higher matching rate is also available for local administrative costs needed to arrange for health care resources, to collaborate with professional organizations and voluntary agencies in strengthening program, and to help with other aspects of local administration.

Another result of this effort is found in the development and publication of a series of guide materials in collaboration with national professional organizations: *Guide to Screening under EPSDT*, with the American Academy of Pediatrics; *Guide to Dental Care under EPSDT*, with the American Society of Dentistry for Children and the American Academy of Pedadontics; and *Report on Professional Provider Participation in EPSDT*, with the American Medical Association's Committee on Health Care of the Poor.

Contracts were also awarded to strengthen technical assistance to State and local programs, to encourage professional provider participation, and to enlist volunteer agency collaboration and support. Special attention is being focused on the developmental assessment and treatment component of EPSDT. Interagency collaboration has been initiated with other programs with a common interest in EPSDT program objectives.

Demonstration projects

Comprehensive Health Care for Children in a Barrio of San Antonio, Tex.

This project was initially developed as a model for the provision of the comprehensive range of health care services available under EPSDT. A research base was established to evaluate its benefit to both the patient and the Medicaid program in facilitating more effective utilization of available care. Emphasis was placed on the recruitment and training of community health aides; educational programs for parents; and a case management system which generated data for case monitoring purposes, and determining cost effectiveness of preventively oriented pediatric care.

The project completed its third year under Section 1110 June 30, 1975. Continuation of the medical care activities is now being funded by the Robert Wood Johnson Foundation, and the developmental assessment and treatment component—*Multiple Impact Therapy for Learning Problems*—is jointly funded by the Hogg Foundation and SRS Section 1115 program.

A Model for a Rural Health Delivery System in a Distressed Area of New Mexico (Cuba)

This project was initially funded to develop and test the effectiveness of a rural health care delivery system providing comprehensive ambulatory health care to a widely scattered population having inadequate transportation and almost no accessible health care resources. Additional objectives included: determining the effectiveness of the use of allied and paraprofessional support-

Continued on page 22.

Child Neglect

Color Me Grey

DOROTHY SUTHERLAND

An examination of the familiar phenomenon of child neglect and its national dimensions is concluded with this, the second part, of a two-part article. Part one appeared in the September 1975 issue of THE RECORD.

Who is the neglected child?

Most of the researchers included in "Profile of Neglect" equate child neglect with poverty in some form. Yet, as Polansky points out, not all poor people neglect their children. In fact, poverty sometimes binds a family closely together and a struggle to climb out of it may develop strengths, mutual ambitions and respect, and loving, helping relationships.

Although most authorities agree that decrepit housing, crowding, unsanitary, and generally demoralizing living conditions seem associated with child neglect, we also find neglect in middle- and upper-middle class homes in the elite suburbs or choice residential sections of big cities.

The tennis-golf-cocktail-theatre syndrome of many women with successful husbands finds their children often left under the supervision of a 10- to 14-year-old babysitter who may be safe and competent enough but is certainly no substitute for the British nanny. Whether or not the child suffers from lack of mother love, discipline, and teaching may well depend on how much attention he gets when mother comes home and whether or not she then puts the children in second place to her husband. The delinquency files are filled with lonely teenagers who have wandered through that kind of childhood and now, "capable" to be on their own, don't know what to do with themselves

when school lets out, link up with other lost and lonely ones, experiment with and get hooked on alcohol, drugs, or sex. They run away, drop out of school, despise their parents and all symbols of authority, and are poor candidates indeed for adult citizenship. The picture is only too well known.

These neglected middle-class children and young people may not be discovered until they get into severe trouble. From then on it is a costly and difficult problem of rehabilitation.

Sophie Tucker is supposed to have said, "I've lived poor and I've lived rich. Rich is better." It all depends.

"Profile of Neglect," however, is particularly concerned with the child who suffers neglect as one result of "the pervading stress that poverty imposes." The authors, paraphrasing one of their consultants, assume that "neglect becomes most likely when a person who is internally disorganized is confronted by circumstances which even rather competent adults would find hard to manage; i.e., when inner chaos is joined by external stress."

In practically all research, the mother is the focus of study in attempts to identify and explain child neglect. For example, Schorr (1968), in an evaluation of the effects of abject family poverty on children, reported that of women committed for child neglect to the New Jersey Reformatory for Women, at least half had been living in housing that was dangerous; "really unfit for human occupancy."

Interviews by Giovannoni and Billingsley (1970) revealed that neglectful mothers were likely to have more children, to be without husbands or to have had recent and severe marital problems, and to have extremely limited financial and other resources for child care. These investigators did not find that the social and familial backgrounds of neglectful mothers were significantly different from other groups of mothers isolated within their neighborhoods or lacking emotional support from their kin. They concluded, therefore, "that neglect is more typically the product of currently experienced stress than of traits which have become part of the mother's personality because of her past life. . ."

Other investigators believe that they *can* discern a generational "cycle of neglect." In this instance, the neglected child would be the child of a mother who had also been neglected. There is some evidence that this perpetuation of neglect is a fact, but it is not conclusive. Polansky, backed by consultants to "Profile of Neglect," describes an "intergenerational cycle of neglect." He adds that this does not discount the impact of current life stress (Giovannoni and Billingsley) but it does imply "that earlier deprivations leave marks on one's personality which make the person less capable of adequate parenting." This is debatable and in any event should not be assumed. Not all neglected children necessarily become neglectful parents.

Most neglectful parents, however, are immature. Serious students agree, Polansky et al. tell us, that in dealing with child neglect we are dealing with "a problem of severe immaturity in a substantive proportion of all neglectful parents." Young (1964) describes them as dependent, unable to carry continuing responsibility, lacking adequate inner controls, and having poor or distorted judgment. She says that "If the behaviour of neglecting parents toward their children could be summed up in one word, that word would be indifference. Children themselves, they reacted as children to the demands and obligations of parenthood and adult life. . ."

Similarly, Bandler (1967), writing as one of a group of Boston researchers, said "the most striking characteristic of these families is that they are families of children . . . the needs of the parents take precedence over the needs of the children. . ."

Other studies show that (as manifestations of immaturity or insecurity) alcoholism, along with drug abuse, are factors contributing to child neglect. The findings, however, leave many questions unanswered as to frequency and degree of neglect and to what extent addiction may be related to or isolated from other causes. Some investigators have found addictive habits passed on from parent to child, most insidiously from pregnant mother to fetus (Densen-Gerber, Odyssey House.) Again, the state of knowledge is inconclusive and merits further development—especially in terms of broader data gathering.

It is safe to say, however, that the neglected child identifies himself best by his behaviour. He may be withdrawn, apathetic, defiant, hyperactive, abusive with siblings and peers, silently resentful—you name it. He may also be disinterested in learning, bored, uncooperative in group activities, unable to assume leadership on the one hand or aggressively seizing "power" roles on the other. The loner and the gang leader—each may be products of some form of neglect; each acts out his frustration in his own way. And each requires.

social and rehabilitation services of various kinds to help him become a contributing member of society.

The literature suggests we need more comprehensive case finding as well as more readily available protective services. For the neglected child is a problem child, and the problem child is usually an unhappy child. In the ambience of neglect as we know it today, it is rare indeed for the growing youngster to be capable of developing realistic hopes for a better life, much less the incentive to do something about it personally.

More than a hundred years ago, all the neglected, abused tykes Dickens wrote about were inspired somehow to rise above their poverty and neglect. They rebelled against their miserable circumstances in a constructive way. And when they "ran away from home" it was to find work for which they were either paid a pittance or given meager board and lodging. But they were better off than before. They eked out an education and were on their way to responsible citizenship and often to comfortable incomes.

In America today, child labor laws do not permit this "up by the bootstraps" solution. Nor does the literature tell us how and to what extent neglected children circumvent their deprivation. Apparently, there is little followup research to describe what happens after the child reaches his majority, in categories of neglected children who receive help vs. those for whom services either were not available or not provided. Neither are there adequate evaluations of the relative merits of one type of assistance vs. another, or of the effect of a single service as against combinations of multiple services.

Unquestionably, there is broad opportunity for more definitive research into the unexplored or little explored areas of child neglect.

What is being done?

The Florida "hot-line" (WATS) reporting system, which the authors consider a good one, seems to be spreading to other States but the extent to which this is happening is not known. Polansky et al. report that *neglect* is mentioned along with abuse in most State laws, but "only a few places have attempted the advertisement-education effort made by Florida. . ." A few communities have used radio and TV spot announcements with subsequent increases in the number of cases reported. But in general, little, apparently, has been done to involve public support in local efforts to prevent or detect child neglect.

In Florida, the public information campaign included four steps: (1) to excite the citizenry about the need to help victimized children; (2) to tell the public what conditions to report; (3) to organize facilities so that reporting was convenient; and (4) to provide the needed services so that those who took the time and risk to report suspected incidences could be assured that their effort was worthwhile.

The Tennessee Department of Public Welfare in Nashville is operating another interesting project—its "Comprehensive Emergency Services to Neglected-Dependent Children" (CES). With funds from the Office of Child Development, HEW, the program developed in 1971 with knowledge that "the existing system failed to provide quality care for (neglected) children (reported) during evenings and weekends." Extending through greater Nashville and Davidson County, CES, like Florida's program, is an around-the-clock service. The Nashville plan includes:

1. *24-hour emergency intake.*

2. *Emergency caretaker service.* Personnel, on a small weekly retainer, are "on call" to step into homes where parents have abandoned their children or are otherwise missing, so that the children may remain in their own homes.

3. *Emergency homemaker service.* For crisis situations, a homemaker is made available for 24 hours, rather than the usual 8. If necessary, the service is provided for an extended time.

4. *Emergency foster homes.* These homes, also kept available on a retainer basis, are ready to accept children for placement day or night.

Although geared to neglect, the emergency services have also been provided because the mother was, for example, hospitalized. These services tend to keep the child in his own environment whenever possible and in general to keep him out of a police station, lacking other custodial arrangements. The key here, as in the Florida program, is letting the public know that the services are available. If it is not known that needed services can be provided, chances are that few referrals will be made from poor neighborhoods. "Only if social agencies have services to bring to a problem do they earn the reputation in a community as representing more than the threat of removing the child." (Varon, 1964).

Because the average neglectful family needs multiple kinds of help, Polansky et al. tell us that "consideration has been given to bringing all the necessary

components under one roof, using each as required for the given case, without the lost time of interagency negotiations. . ." There is the additional advantage of opportunity for the client to identify with a *center*, not just an individual, and to feel confidence in the group to whom he is known as well as in the familiar surroundings.

The authors cite as an "outstanding example" of this approach, the Bowen Center, under the auspices of the Juvenile Protective Association of Chicago. This project also was initially financed by a grant from HEW. It combines casework, a day care center, a remedial school, parents' groups, emergency foster care, and sheltering—all in one building. Because of their multiple services, staff were able to sustain continuity with some clients for "unusual lengths of time" and to reach "deeper levels of communication." An outcome, therefore, "has been to provide us with case material demonstrating in great detail the psychological dynamics behind what, on the surface, seems to be simply another inadequate family. . ."

Federal assistance available

Federal funds can be obtained for all projects similar to those described provided, of course, that they meet the Federal quality standards.

Polansky et al. call the community-based, multiple service agency founded in the psychosocial approach, a "major new treatment design for child neglect," conceivably the "wave of the future."

First, under P.L. 93–247, HEW may make grants to and contracts with public agencies or nonprofit private organizations (or combinations thereof) for demonstration programs and projects designed "to prevent, identify, and treat child abuse and neglect."

This law also provides grants to States. The grants are to be used to help the States develop, strengthen, and carry out effective neglect prevention and treatment programs. (None of the money, however, can be used for construction.)

For a State to qualify for this assistance, the Federal Government expects that States will tell the general public about the problem of child abuse and neglect and the facilities and prevention and treatment methods available to combat them. States are also expected to give preferential treatment to parental organizations combating child abuse and neglect.

A new two-way source of assistance is available through Title XX of the Social Security Act. Under this title, States and citizens work together to make their social services programs "fit the needs of people in local communities as effectively as possible." Among the kinds of services it is hoped States will offer are several related to the needs of neglected children: homemaker services when a mother has to go to the hospital; emergency and followup service to protect a child from abuse or neglect; after school care for children so their mothers can have job training and a job; information and referral services; emergency shelter to protect a young runaway from exploitation; competent part-time care for a handicapped child; family planning services.

Also, under Title XX, the SRS-Public Services Administration may make grants to individuals and organizations for projects related to all the aspects of child neglect we have been discussing and, one hopes, for new and innovative methods of exploring the subject more definitively and in new areas.

A further Federal tool, expecially useful in diagnosis and treatment of the neglected child, is the Medicaid Early and Periodic Screening, Diagnosis, and Treatment program for young children, also a State-Federal partnership program, now in effect in all States. To the extent facilities are available (and they vary throughout the country), the EPSDT program helps detect signs and symptoms of abuse and neglect, even hidden ones, like hunger, fear, listlessness not due to physical illness, and many other subtle indicators. It can then follow through with treatment of the child and, with the social worker, devise plans for rehabilitation or reeducation of the neglectful parent or parents.

Thus, as Polansky et al. say, in view of where we stand in the state of knowledge of child neglect, "it appears that quite a lot of good is being done at least to salvage the lives of thousands of youngsters. As always, it seems likely that much more is known by most competent workers than is generally being used. But this is not a field of which it can now be truly said, 'Action, not more knowledge, is needed.' We need both."

Miss Sutherland, now retired, was Director of Division of Publications, Office of Public Affairs, SRS.

Note

1) "Profile of Neglect," Polansky, Hally, and Polansky; HEW-SRS Community Services Administration, 1975. (SRS) 75–23037

For the Blind: *A* Special Focus

Blindness, in proper perspective, is a physical disability which causes certain problems. Disrupted life patterns must be faced when sighted people lose their vision. Blindness is not the equivalent of any other handicap. This circumstance reflects a double impact: the reality of severe visual loss with related social dependence, plus an emotional overlay composed of many elements. Excerpted here is a report prepared by the Public Services Administration to help State social services departments enrich and expand programs to the blind.[1]

For the sighted, personal concerns are likely to include the common dread of becoming blind, the feeling of guilt for not being blind, uncertainty about ways to assume a helping role, and general mystification over how blind individuals manage even ordinary tasks and often display such cheerful attitudes. By gaining deeper insight into the meaning of blindness to the client and his relatives, as well as recognizing her own inner feelings concerning loss of sight, the social worker will be better prepared to offer both suitable and acceptable services.

The attitudes and reactions of individuals with serious visual impairments and the social implications of sight loss are not well understood. There are many misconceptions about the capabilities of blind persons.

Common caseload characteristics

The number of blind persons in this country can only be estimated because there is no method for obtaining a reliable and current count. However a recent study[2] by the Metropolitan Life Insurance Company of half a million blind people in the United States showed that:

- Three out every four blind persons are over 45 years of age.
- Three conditions account for approximately half of all blindness: retinal disease (in which complications from diabetes loom large), cataracts, and glaucoma.
- The extent to which the rate of blindness is linked to age is underlined by the following figures: at ages 45–64 the rate of blindness is 200 or less per 100,000 population; at 65–74 years it is 440; between 75–84, 900; and at 85 years and over it reaches 2,600, or more than 13 times the rate for the 45–64 age group.
- The highest regional rates are in the East South Central, South Atlantic, and West South Central regions of the country which are also characterized by below average income, poor health services, and a high proportion of nonwhites.

Children and blindness

Children who are blind can be divided into two groups: (1) those with a single handicap of blindness and (2) others who are multihandicapped; i.e., they have a severe visual handicap plus one or more additional impairments such as mental retardation, cerebral palsy, hearing loss, or an orthopedic problem. The combination of such defects is not unusual for "rubella babies."

Since a child who is entitled to SSI payment will not be suitable for vocational rehabilitation planning before his mid-teen years, the social worker has a particular responsibility to offer services to his family and to follow his individual development. Full utilization of medical resources is a major aspect of this task.

Beginning January 1, 1974, blind and disabled children for the first time became eligible as individuals for Federal cash assistance. (A large number had been receiving Aid to Families with Dependent Children, Title IV-A.) On that date, many were transferred by State departments of welfare to SSI. In general the great majority of these young recipients continued to be entitled to Medicaid (Title XIX). States, however, have the authority to limit Medicaid coverage based on their January 1972 standard of need, so inclusion of the children may not always be automatic, particularly for the medically needy. Thus it is necessary that the service worker understand the specific eligibility provisions of her own State Medicaid plan.

Eligible blind children are entitled to all the medical and remedial care and services included in a State plan for medical assistance. Actually these children comprise a high risk population due to the severity of their eye problem and its effect on sound growth and development. In addition the SSI population under 21 years of age belong to a low-income group eligible for special health care—also a required part of Medicaid. This is made possible through the program of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Through EPSDT the young from poor and marginal income families are assured for the first time the scope of preventive health care that has been lacking for far too long.

There is real danger that in the area of health, the blind person's visual disability and related eye care (if any) obscures the necessity of regular medical attention to the rest of the body. The worker is in a strategic position to counteract such tendencies. The correction or reduction of treatable conditions, even minor ones, can enhance the handicapped person's self-image. At the same time, continuity of care serves as evidence that others are concerned with his situation.

Needs of infants

Parents do not know what to expect of a blind child or how to encourage his optimal development, and this knowledge is not part of the service worker's expertise either. Rather her role is to recognize with the parents and in behalf of the child that the demands of everyday living for both are more complicated due to the loss of sight but are not necessarily overwhelming since special kinds of aid are available. She should make every effort to locate or to assist the parents in finding appropriate resources, including qualified counseling. The worker should encourage the parents to accept and utilize these resources since parental cooperation will be the essential foundation for success. Assistance should not be postponed either, because delay may diminish the child's chances for improvement.

Multihandicapped children

In a recent research study [3] made by the Rand Corporation and sponsored by the U.S. Department of Health, Education, and Welfare, a small sample of families with multihandicapped children were asked to rate their children's most important service needs. First on the list was education; after that, medical services and sensory aids. This group of families—selected from an Eastern, Western, and Mountain State—had trouble learning where services were available. They also found that the qual-

ity of service was less than needed and that the mix of services the children required were not all within a reasonable distance from their homes. Although public social service staffs are familiar with all of these problems, there is an extra urgency for action for families with multihandicapped children because opportunities for correction and learning are the most favorable during childhood and youth.

Linkage with other care providers

The social worker's main function may well be one of firm linkage—that is, joining family to resource and vice versa—with a sustaining interest to maintain the continuity of services, again between clients and providers. The process is time consuming, often tedious, and may result in few thank you's. Nevertheless the activities serve to act as an agent, perhaps the only one that binds essential services together for the benefit of their mutual clients.

In summary, the service worker seeks to assure that the parents or caretakers of eligible SSI and AFDC children, especially during the latter's formative years, receive the best individual guidance in child care and development that is available. Because of the unique nature of the rehabilitation and educational requirements of these children, the most significant and lasting social service may be to see to it that their parents have access to the appropriate resources for this guidance. The outcome of all efforts in behalf of children who are blind should be to encourage maximum participation in the usual experiences of childhood such as regular schooling, recreational outlets, and a share in family and community life.

Young and middle adult years

The young adult and the middle aged person who are blind and who qualify for SSI will be considered for vocational rehabilitation provided by their State programs. The service worker's function in conjunction with rehabilitation cases is concerned with supporting the training or retraining plan to assure a successful outcome.

Recreational needs and resources

Whether the client's age, interests, and health status favor individual and sedentary pursuits or group and outside opportunities, there will be a variety of recreational outlets from which to select. The service worker should encourage participation in the activity of choice, with the family's concurrence. If transportation to reach the recreation location presents a barrier, the worker will need to facilitate travel arrangements either through her agency or a volunteer source.

A positive experience with a chosen leisure time activity provides many rewards and, by extending the blind person's horizon, can help him move on to even wider participation in a larger world. For example, for those who expect to enter the labor force, recreational outlets shared with the nonblind are part of and contribute to the reality and mastery of living in a sighted world. Especially for the recently blinded, outside interests serve to counterbalance the despondency and boredom that are likely to set in when active medical treatment is finished and when, after their initial concern, the attention of friends begins to wane. Often all that is needed to effect this "positive experience" is a knowing and helpful person to bring client and resource together.

Elderly and blind persons

Because poor sight may slowly progress to the level of blindness and at the same time be painless, an older person with other health problems that do hurt and hinder tends to complain more about them. But the presence of these other impairments emphasizes how necessary it is to protect and restore any useful sight the individual may have. The too ready acceptance of debilitation as a normal part of aging also discourages utilization of comprehensive medical care. Consequently many older people allow themselves to become worse through neglect that is often due to ignorance.

It may be a moot question whether blindness in an old person is a problem of aging or of sight loss since they have so many common factors. Certainly the range of services that benefit all elderly is of equal or even greater value to the elderly blind. There are differences in this stage of the life cycle as in earlier periods between those who were born blind, became blind as youths or as adults of working age, or lost their sight gradually or suddenly in old age. These are different kinds of events, and effective social service planning will be cognizant of each individual's unique response to his losses.

When someone who is already deaf becomes sightless, the combination is often overwhelming and calls for special help and understanding. For any visually handicapped age group, preservation of hearing is a "must" goal. The blind have to rely heavily upon this sense for auditory cues and communica-

tion to counterbalance the visual deficit, since the latter has greatly reduced their capacity for gathering information.

Blindness late in life compounds other deprivations that are occurring such as loss of work and income, illness or death of the marital partner, a diminished role in the lives of grown children and in community affairs.

The necessity of assuming everyday tasks without useful vision—often combined with other sensory deficits—creates severe stress at the time older persons have less stamina and greater difficulty in learning substitute ways. The principal assistance they want, need, and can manage may consist of providing instruction on how to move safely around their living quarters and to care for their personal needs.

The Institutionalized

Many who are old and blind live in hazardous circumstances. They may require the protection of foster care, boarding situation, or a medical setting. With worker encouragement the transition to a protective environment can often be made without great distress. Interpretation of the special needs of this group to the administrator or caretaker in the new setting may also be up to the worker.

Though blindness is a primary factor determining the organization of the lives of the visually handicapped and influencing their relationships with others, blind individuals are more like than different from the sighted. With this understanding, the uniqueness of each client becomes more visible to the worker.

Use of these concepts will assist the agency worker in establishing a meaningful dialogue with clients. It is the worker's responsibility to acquaint and encourage client use of the agency's resources and those of allied programs. A mutual objective of their association is to enable the visually handicapped client to reach and sustain his upper limits for personal and economic independence.

A single need readily met by a single service is more often the exception than the rule in the provision of social services. Thus the social worker should have a combination of factual knowledge about all the resources of her own program and the services available from related organizations, in addition to skill in communicating with others and facilitating client progression toward attainable goals. A number of the latter—such as instruction in mobility, personal adjustment, and educational and vocational training—are in the province of related programs. An important social service responsibility is to make sure that SSI recipients and other eligible persons are informed about and assisted in using such opportunities. The firm linkage with outside providers of specialized services is a collaborative endeavor that sometimes continues for a lengthy period. The exchange is necessary to keep patterns of service in balance and responsive to changes in plans that frequently accompany both intra- and inter-agency work.

The service worker becomes the image of the social service agency to client households since she is the only personal representative of the program that families are likely to meet. Whether the blind individuals are young or in middle or old age, the social worker is in a propitious position to learn "how life goes for them," about their accommodation to visual loss, about their expectations for the future. These indicators should focus agency attention on clients' assets that can be preserved and developed.

The helping process is relevant even though the gains may not be substantial. Most blind people, like the rest of us, respond favorably to a sincere approach. When free to make informed choices, there should be movement toward achievements that are consistent with their interests and community opportunities.

The public agency setting offers its service staff a rich though often soul-searching opportunity to know and participate in improving the daily existence of a large number of blind citizens. This, in brief, is the mission embodied in all the related Federal, State, and local social service legislation and directives. The mission only becomes reality when client and agency social worker together translate intent into actual services.

Notes

1 *Social Services for the Blind (SRS) 75–23039. Public Services Administration, Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, Washington, D.C. 20201.*

2 *Profile of Blind Persons.* Statistical Bulletin 54:9–11 (July 1973). New York: Metropolitan Life (1 Madison Avenue, New York 10010).

3 Kakalik, Brewer, Dougharty, Fleischauer, Genensky, and Wallen: *Improving Services to Handicapped Children: With Emphasis on Hearing and Vision Impairments.* Santa Monica, Calif.: Rand (1700 Main Street, 90406) 1974. 329 pp. (p. 277)

Kansas and Nebraska improve EPSDT effort

Both Kansas and Nebraska have initiated programs to improve their Early and Periodic Screening, Diagnosis, and Treatment programs for children by applying State Quality Control procedures to the EPSDT program.

Review procedures have been established through the use of Federal guidelines and Regional Office technical assistance, enabling the States to read case records in each county to establish county office compliance with State and Federal regulations.

With this method, the States will be able to identify and correct potential problem areas in advance of the Regional Office review.

Nebraska will use a special team to review records, while Kansas will use specially trained district supervisors' staff to perform the function.

Proving paternity is aim of research studies

Two universities have been awarded SRS research grants in the area of establishment of paternity in support of the new child support enforcement program.

The $98,375 grant to the Center for Policy Research, Columbia University, will be used to study the use of blood tests to establish paternity. The Columbia study will evaluate existing laboratories, make recommendations regarding additional personnel and equipment, and estimate costs of needed expansion. An evaluation procedure for monitoring accuracy of blood testing will be developed. In addition the potential of polygraph data as a supplemental means of determining paternity will be examined.

Under its grant of $92,008, the Center for Health Services Research, University of Southern California, will evaluate the judicial willingness to accept blood tests and polygraph tests as evidence of the probability of paternity. A comparative study will be made of different procedures and systems for establishing paternity with particular emphasis on outcomes and cost-effectiveness. The USC study will also analyze perceived barriers to changing procedures in the direction of more cost-effective systems and make recommendations for overcoming such barriers.

Medicaid cuts ordered restored in Connecticut

U.S. District Judge T. Emmet Claire has ordered a temporary stop to the $2.3 million in cuts for the Connecticut Medicaid program.

In his ruling, Judge Claire accepted legal aid lawyer arguments that the cuts could cause "irreparable harm" to poor persons who depend on Medicaid for critical medical services.

Judge Claire found that officials violated State and Federal laws in not giving Medicaid recipients 10 days notice on the cuts and in not consulting with the State professional advisory committee.

He added that he might modify or dissolve his order if the State complies with Federal law relating to Medicaid procedures.

N.H. welfare ban on elective abortions ruled discriminatory

U.S. District Court Judge Hugh Bownes has ruled that if New Hampshire continues to pay costs of medical treatment for pregnancy cases under Medicaid, then it also will have to pay for elective abortions under the same program.

Judge Bownes said that to withhold payments for women seeking elective abortions constituted discrimination against one group of pregnant women as opposed to the other group receiving reimbursement for full-term pregnancies.

He rejected the State's contention that government regulations governing the State's participation in the Medicaid program allows State authorities latitude in shaping their own program. He allowed only that the State was not obligated to participate in the program, but held that participation bound the State to treat both classes of eligible pregnant women equally.

In response to the State's contention that elective abortions were not connected with saving the life or health of the mother, he judged that such abortions can be a necessary service that may well be in the best interest of the recipient involved.

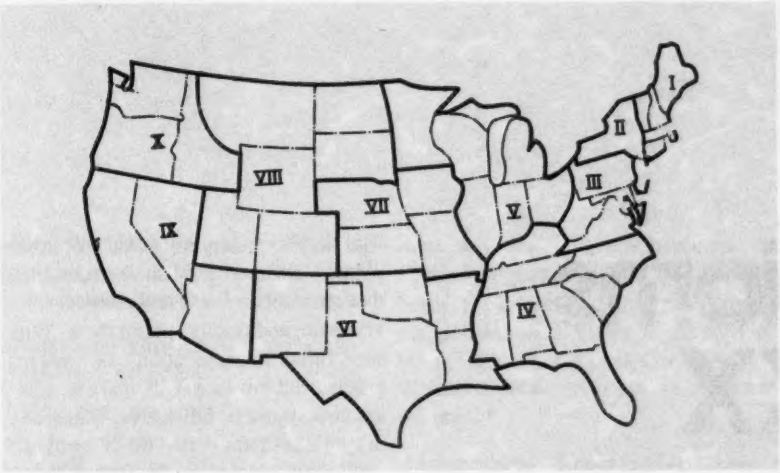
The Judge's decision may be appealed by the State.

Bilingual notices not required of Mass. agencies

The Massachusetts Supreme Judicial Court has ruled that official notices sent by Massachusetts courts and administrative agencies can be written in English, even though the persons who receive such notices cannot read English.

In two separate cases involving two natives of Puerto Rico and one from Portugal, the court said since English is the language of the State and the United States, people who are not literate in English have a duty to seek assistance and translation when they are properly served with official papers in that language.

Chief Justice G. Joseph Tauro, who wrote the unanimous decision, declared, "This is not an official multilingual



country, and notification of official matters in the sole official language both of this Nation and this commonwealth is potently reasonable."

Medicaid cutbacks averted in Iowa

The Iowa Legislature has passed a $13.8 million supplemental appropriation which will permit Iowa's Medicaid program to continue at its present level through this fiscal year.

The State had been in the process of proposing cutbacks in the Medicaid program.

Tenn. requires fingerprints on AFDC and foodstamp applications

A new procedure requiring fingerprints on food stamp and AFDC (Aid to Families with Dependent Children) applications was announced by Horace Bass, Commissioner of the Tennessee State Department of Human Services.

According to the Commissioner, this procedure should help protect recipients against theft of checks and reduce fraud complaints against recipients.

The Commissioner also hopes this action will help the agency prove that very few legitimately needy people cheat in the welfare programs.

Problem of access to EPSDT services eliminated in Tex.

Recent reviews of EPSDT programs in four Texas counties indicate that as a result of the Texas Statewide Transportation System the problem of access to EPSDT services has been eliminated.

The system uses methods ranging from radio-dispatched vans and minibuses in Houston to a contract with a local cab company in Lufkin.

ACLU gets restraining order for a N.J. law on Medicaid abortions

The New Jersey chapter of the American Civil Liberties Union has obtained a temporary Federal court order restraining the State of New Jersey from enforcing the new State law banning Medicaid payments for abortion except to save the mother's life.

Judge George C. Barlow in Federal District Court in Trenton signed the order in response to an ACLU suit challenging the constitutionality of the statute.

Oklahoma provides work experience for AFDC parents

The Oklahoma Department of Institutions, Social and Rehabilitative Services, in the summer of 1975, instituted a voluntary work experience program for parents of AFDC children to give them job experience in the State's public agencies.

By the end of January this year, 940 people had participated in the program and 51 had secured full-time jobs. In addition to the savings from eliminated or reduced welfare payments, the agency reports a bonus in improved community attitudes toward welfare recipients. Reportedly, the community now sees that welfare recipients are making an effort to help themselves become self-supporting.

KY AFDC Unemployed Father program tied to unemployment rate

Since Kentucky put its AFDC-Unemployed Father program into effect in July last year, the program has been operating on a month-to-month basis, based on a monthly determination by the Secretary of the Department for Human Resources that the statewide rate of unemployment exceeds 6 percent.

However, legislation before the State General Assembly in February would make this program a permanent part of the State's IV-A plan. Operation based on the unemployment rate in the State would be removed.

Three Axioms for Title XX

THOMAS N. DUFFY

Planning year one is done. State social service planners all over the country are leaning back from their desks, wiping the figurative sweat from their brows and heaving sighs of relief. Half afraid to think about Title XX's second year planning, they're thinking about what went right and wrong with the first-year plan.

Overviews of the first year are not common currency yet; the planners who did the work have to be wondering, "How did we do?" From the point of view of the working official of any level of government, Federal, State or local, there is a clear and definite answer.

"You did well."

There is one overwhelming fact about the planning of Title XX's first year. It got done! The time limits imposed, the new areas to be explored, the degree and timing of guidance all worked to make the first-year plan an impossibility. But by whatever methods and motivations, the plans were formulated, published, commented on and revised, an achievement of which to be proud.

Without realizing it, the States accomplished another one of the major goals of Title XX. They made it a varied State program quite different from a standardized Federal one. Despite feelings of constraint about the law, the regulations, the Program Regulation Guide and other aspects of what was seen as Federal control, the 51 plans are full of the richness and variety that only individual initiative can give.

An SRS analysis of the proposed State plans showed no two even remotely alike. To compare eligibility standards, the analyst had to set up nine different qualitative categories before the States could be fitted in. Day care comprised as little as 4.4 percent of some States' proposed Title XX expenditures to as much as 55.3 percent. There are 51 different sets of services proposed for the developmentally disabled. Even Information and Referral, considered so basic and universal, is not proposed in all State plans. Local needs and local desires have been expressed in a way not possible before. "I did it my way" is the real theme.

The kind of efficiency that made the 51 Title XX plans possible is self-limiting. The limited time available made speed a necessary condition. Speed limited the amount of time to design formats, acquire data, formulate plans, write and publish them, submit them to public review and comment, revise them and finally submit them. With such limits in preparation, the finished product did not satisfy its makers, service consumers or advocates, much like the tiny gaps in do-it-yourself wallpaper, glaring to the paperhanger, are never noticed by anyone else.

There was no way to acquire every fact needed. In many instances, there wasn't time even to locate all the possible sources of information. This left a knowledge gap.

Most of the information presented to State planning agencies had some bias built in. Inputs by service providers, either in the planning or comment stages, tended to emphasize the services they provide. Advocates of client groups such as the blind, elderly, and developmentally disabled, all see the problems in their area of interest as the most serious and deserving of intensive support. Whatever the purity of motive, the information presented was slanted.

The depth of citizen reaction to the plan was in many cases limited by time and process. The required newspaper ads are not a really determined outthrust.

These limits in knowledge, objectivity or reaction are not criticisms of the first-year plan. They were necessary if it was to be accomplished. They do point to other, better ways that could be used to develop a second-year plan.

One major resource which was not used in first-year planning is local government. It can be used for the second year. Cities and counties have been heavily oriented to planning. They are heavily involved in human services.

They should be part of the Title XX planning process. The rationale for this involvements rests on three axioms:

Axiom one: Title XX is a State discretionary program.

This does not sound very earthshaking. The law says so, the regulations say so, SRS says so. The practical effect rises from a corollary which says that someone who is dealing from strength can afford to deal generously. You can accept advice easily if you are not bound to follow it. Absolute decisionmaking power confers a good deal of freedom in seeking information and opinion. The imperfections in the process that first year planners demonstrated to themselves will incline them toward reaching out for help.

Axiom two: The Federal system has three levels, not two.

The Constitution, it is true, talks about two levels: the Federal Government and the States. The Constitution, though, never envisioned two things which have changed our whole system of government. The population of each of the 13 colonies was less than the population of what we would now consider a medium-sized city. In those days, a two-level system was able both to inform its citizens and to be aware of every current of thought among them. This is impossible for a two-level system in a nation of more than 200,000,000 people.

The intergovernmental system we have seen arise with grants and cooperative programs is a new phenomenon. Its full flowering dates from World War II. If local participation in State programs and activities does not occur in much the same way that the States participate in Federal programs and activities, then the benefits of representative government are not available either to citizens or their State or Federal Government. Without local government, the system is incomplete.

Axiom three: Local government knows more about its people and its area than State government does.

Concentration of attention, interest, study and work develops intensive detailed knowledge. County and city officials have that concentration. It is not found in those who deal with populations or areas 20 times larger.

The benefits of this intensity should be, but have not been available to Title XX planning. The wealth of fact available from county or city sources will fill gaps in knowledge of needs and resources in human services. Perhaps more important, the fullness of knowledge gives a balanced view of needs, their extent, and their severity. Resources can be allocated with better balance.

However well allocated, Title XX funds have a definite limit in every State. Most States plan to spend their whole allocations. They will be the first to say that there isn't enough. Title XX won't solve all our problems, much less achieve its own basic goals. More is needed.

Several programs operating in county and city governments are aimed at the same target populations as Title XX. They are aimed at solving parts of the problem clusters that Title XX clients have. Often the particular problems themselves overlap. To allow Title XX to operate at random with these other programs is wasteful and irrational. A tandem approach might be helpful.

Social service planners tend to be familiar with the locally-operated programs sponsored by HEW, such as aging, alcohol, drug abuse, mental retardation, and mental health. They are less likely to know much about Department of Labor or Housing and Urban Development programs that impact in their area.

Manpower programs operate under CETA (Comprehensive Employment and Training Act). Planning and programs are carried out by local consortiums and prime sponsors to provide jobs and to train the unemployed to take them. Many trainees need social services to assist them through the process of training for, getting, and holding jobs. Employment and self-support are mutual goals for CETA and Title XX. They should be applied together.

CETA public employment jobs can provide both a vehicle and a training ground for social services. The whole range of paraprofessional jobs associated with social services, such as home health aides or child care aides, can be filled by those who are now recipients of services and financial support. CETA can provide job training, and sometimes the job itself, to furnish services. This prepares the client for productive work, extends the amount of service itself by reducing costs, and ends up with a skilled worker less dependent on welfare programs.

The amount of useful mixing of programs is the measure of the ingenuity of their practitioners.

The Community Development program administered by HUD is carried out by cities over 50,000 and urban

counties. Like CETA, it concentrates on people familiar to Title XX, "Persons of low and moderate income." Often thought of as a bricks-and-mortar program, the program is aimed at more than streets or houses. With a concern for quality of life, it aims at the whole human environment of its target neighborhoods.

Fort Worth, Texas, for example, enunciates ten short-term goals for its first-year Community Development program. Of these no fewer than six are readily identifiable as human-oriented activities closely allied to social services. Among them are personal safety, access to community and recreational services, employment opportunities, social services for public housing tenants, education improvements, incentive for self-improvement.

The Community Development program is characterized by rigorous studies of its target areas' physical and social characteristics. Extensive citizen involvement helps formulate plans for the program. A detailed evaluation scheme is developed to critique ongoing operations and to improve future ones.

These features are particularly appropriate to social service programs. Even more attractive from the service planner's point of view is the characteristic of Community Development funds that makes it eligible to match other Federal funds, including Title XX.

The far-reaching step is engaging them in the service of Title XX. States with county-administered social welfare and service systems have had some awareness of their counties in first-year planning. Where local involvement has occurred, it has not so far been in cooperation with city government, United Way, and the local Counsel of Governments. Even less interaction is characteristic of the State-administered States. In either category, more involvement is necessary. The method of cooperation will be roughly the same; county-administered States have a better mechanism for reaching the local areas.

Remembering our first axiom and the State discretion involved, it is probable that the first task in which the State will use local government is fact-finding. Judgmental activities will come after a base of joint working experience has been laid. Needs identification and resource inventory come readily to mind.

These take advantage of the strengths of local government: a base of existing knowledge and the availability for intensive study. To a greater or lesser extent, depending on the individual agreement, evaluative data will be built into the information supplied, perhaps about relative severity of needs or the quality of providers' services.

As the system progresses, evaluative techniques such as program or zero-base budgeting might be applied to recommendations for the allocation of Title XX funds by service type and probably even by service provider. It is important to remember that the State retains the ability to control the pace of this progress.

Besides the city and county involvement, United Way and the regional Council of Governments may well play a major role. United Way is helping to sponsor many local services through its planning and matching capabilities. This role cannot be ignored. The regional planning efforts of COGs can, in many cases, be applied to the human resources area.

A State move toward extensive local interaction in Title XX is a giant step, one which must be taken with care. The policy and mechanics of joint planning need first to be enunciated in carefully worked out goals and objectives. These will have to be broad enough to do a useful job, but cautious enough to guide the experiment along mutually agreed upon pathways.

The changes and risks are so extensive that it is wise to consider the pilot or demonstration approach. The State will want to identify a city-county complex where cooperation, or at least the seeds of it, already exist. If there is a strong United Way or COG, this should be considered. Once the area is identified, a working partnership needs to be formed and a working plan set.

One of the elements of this plan will be money. Nothing comes free, unfortunately. How much a project would cost is for the participants to decide. The sources of it will vary in each location. If a State is not planning to spend to its Title XX limit, Title XX planning funds could be used to draw some demonstration money from HEW. CETA or Community Development funds are possible, as well as private money.

SRS has discussed such pilot projects with the National Association of Counties and the National League of Cities. It appears that a project to develop working materials, broker some introductions, and provide technical assistance for up to ten pilot projects nationally may be forthcoming.

Mr. Duffy is City Representative, National Center for Municipal Development, National League of Cities/U.S. Conference of Mayors.

Publications and Films

The editors of THE SOCIAL AND REHABILITATION RECORD regularly receive notification of the release of new publications and films of interest to readers.

Each issue of THE RECORD will carry a selected list of these publications and films with brief descriptions of their contents.

Please address all inquiries to the addresses given in the listing.

The First Two Years: Parents Anonymous of Michigan. Lucile Cantoni. Parents Anonymous of Michigan, 13627 Gratiot Ave., Detroit, Mich. 48205. 34 pages, (Contribution: $3 or more.)

The story is told of how one community geared up to meet the problems of child abuse. In chronicling the birth and growth of this organization, the pamphlet can be used as a blueprint in planning and developing such a group.

The publication looks into all aspects and inter and extra group relationships and helping techniques, such as intake, crisis calls, parents and professionals, sponsors, child care helpers, publicity, and relationships with other agencies.

Social Service Delivery: A Structural Approach to Social Work Practice. Ruth R. Middleman and Gale Goldberg, editors. Columbia University Press, 562 West 113th Street, New York, N.Y. 10025. $10.

Two experienced practitioners and scholars describe here the practice principles for a model of social work practice based on a philosophy of social welfare through social change. The authors have developed a generic social work methodology that is applicable whether the client is an individual, a family, a group or a community.

The aim is to adjust the environment to the needs of individuals by assertively bringing to the clients the material and personal resources that make for social well-being.

Students of social work and workers at all levels should find here ideas for effective practice.

In Part one, the authors discuss such areas as a frame of reference for practice, specialization, and social work roles. Social work skills receive attention in the second part; and the organizational context and the social science base form the concluding section.

The appendix presents an episode from an interview at a teen center. Identified in bracketed notes are intervention behaviors that are covered in various chapters of the book.

The Custody Trap. June and William Noble. Hawthorn Books, Inc., 260 Madison Ave., New York, N.Y. 10016. $7.95. 163 pages.

In *The Custody Trap* June and William Noble spotlight this trap which is affecting the lives of many people today, and offer some solutions to benefit both parents and the children involved.

Commonplace custody cases are reconstructed through intimate case histories, interviews, correspondence, and court transcripts. These cases show the bitterness caused by the present adversary system of divorce, the fate of children caught in the awards game, and their use as weapons in divorce and settlement trading.

Included in the book is information about legal procedures, laws of various States, special organizations fighting for the rights of individuals involved in divorce and for the children who are often the punching bags.

The Nobles have presented here much information drawn from their own experience over the custody of children.

The Adoption Adviser. Joan McNamara. Hawthorn Books, Inc., 260 Madison Ave., New York, N.Y. 10016. $9.95. 233 pages.

This comprehensive reference manual provides guidelines to parents and professionals concerned with adoption. It tells prospective adoptive parents not only what to expect but how to prepare for the unexpected.

Areas covered in the book include reaching the decision to adopt, finding a child, independent adoptions versus agencies, adoption by single parents, adoption and the law, and what to do after adoption.

The book contains a listing of citizen adoption groups in each State, family planning resources, and counseling services available to adoptive parents.

Work and Welfare in New York City. Miriam Ostow and Anna B. Dutka. The Johns Hopkins University Press, Baltimore, Maryland 21218. 93 pages. $7.95 cloth, $2.75 paper.

This study of work and welfare in New York City represents the merger of two major concerns of Professor Eli Ginzberg, founder and director of the Conservation of Human Resources Project, that is the social and economic waste of human resources caused by long-term unemployment and the operation of present day metropolitan labor markets. He believed that the debate over social welfare policy might be illuminated by an analysis focusing upon these issues.

In examining the work experience and work-welfare relationship of a sample of New York public assistance recipients, this monograph explains, 1. how the sample was selected, 2. offers an analysis of the complete public assistance history of the sample, 3. presents the current employment status of the sample and analyses of differences among those working, not working but looking for work, and those neither working or looking for work, 4. analyzes in terms of industry, occupation, wage rate, and duration, the nature of the jobs held both currently and formerly by the welfare sample.

The final chapter summarizes the findings and presents policy implications of the study, as well as suggestions for further research.

Education of the Spanish-Speaking Urban Child. Earl J. Ogletree and David Garcia. Charles C Thomas, Publisher, 301-327 East Lawrence Ave., Springfield, Illinois 474 pages. $22.75.

This volume discusses the social, cultural, linguistic, educational, and psychological barriers Spanish-speaking persons face in their attempt to enter middle-class America.

The book is divided into nine parts. Whole sections are devoted to the problems of segregation and integration, expectations and self-concepts, the schools and the Spanish-speaking child, problems of language and learning, cultural influences on achievement and intelligence, bilingual education, reshaping teacher education for the Spanish-speaking child, and other educational issues.

Films

Community Health in Action. 22 min. Color. International Film Bureau, Inc. 332 South Michigan Ave., Chicago, Ill. 60604. Sale: $265; Rental: $12.

This documentary of good community health planning combines the best features of several community programs. The film was produced in cooperation with the National Health Council by Sam Orleans and Associates, Inc.

Homefires: 28 min. Black and white. International Film Bureau, Inc. 332 South Michigan Ave., Chicago, Ill. 60604. Sale: $185; Rental; $12.50.

This film presents the salient aspects of the Homemaker-Home Health Aide Service, a form of assistance provided by health and welfare agencies when a family or individual cannot maintain living and household routines during a time of stress or crisis. Through three case histories, the film shows the relationship between agency staff and their supervisors, as well as the duties and responsibilities of the Homemaker-Home Health aide herself. This film was sponsored by the U.S. Department of Health, Education, and Welfare.

Continued from page 7.

ing health care personnel recruited from the community, and after training, working under skilled supervision; determining the effectiveness of such care in improving health status as well as assessing the cost effectiveness of this effort; and determining the applicability of this model system to other distressed rural areas, in whole or in part.

In addition to a comprehensive health care clinic in a central point within the area (Cuba), field stations were established within 50-mile radius points and a network of communication and transportation established, with emergency ambulance service available, and a back-up hospital arrangement about 90 miles away.

After three years of operation, the medical care activities are now being funded by MSA's Rural Health Delivery Project Program and the Office of Indian Affairs. A developmental assessment and treatment component established two years ago is continuing operation under SRS Section 1115 funding. Physical and developmental assessment and treatment of the children is carried out in collaboration with the schools.

■ *Implementation of EPSDT in Child Day Care Centers and Bicentennial Expansion in Washington, D.C.*

The National Child Day Care Association has been demonstrating one approach to an improved delivery system for EPSDT through an on-going day care system for preschool children. The expanded SRS Bicentennial Project will extend coverage of the project to include children up to age 14; include a wider range of service; coordinate activities with the D.C. Department of Human Resources and the public schools in the area; train paraprofessionals; and design and test its own developmental assessment tool. The project intends to demonstrate the application of the full potential of EPSDT under near optimum conditions; to evaluate the cost benefit to the program of this approach; to evaluate the increased opportunity thus provided for normal growth and development of low income children; and to provide a model that can be replicated in whole or in part in other parts of the country. (Film available from D.C. Project)

■ *Implementation of EPSDT in Model Areas (Urban and Rural) in Contra Costa County, California*

This project is an outgrowth of the ***Health Care Outreach Project*** in Richmond, California, initiated by MSA in July 1971 to demonstrate the effectiveness of integrating social and health care services, and the training and use of paraprofessionals in providing health-related supportive services. (Filmograph on this project available from the National Audio Visual Center, Washington, D.C.)

The core staff and the expertise and knowledge gained from this project were incorporated into the present project which emphasizes case management, training and use of paraprofessional staff, linkages and coordination with private and public child health services, health education, and increased citizen participation in the design and delivery of health care services. Evaluation is being made of the cost effectiveness of this approach, as well as the influence of geographic and racial-cultural differences on the delivery of EPSDT services.

■ *Health Services Research Institute, University of Texas, Health Science Center, San Antonio, Texas*

A common data base was developed for each of the above four demonstration projects by the Health Services Research Institute under a Section 1110 grant, which provides for collecting comparable evaluative data from all the projects at the time of first patient contact through case completion. The record system of each project was designed or modified to ultimately yield comparable information on the cost effectiveness of alternative methods of case finding, screening, diagnosis, and follow-through activities; and to enable the utilization of health services by project children to be compared with samples of children screened in the regular EPSDT system.

Following the development of a ***Handbook for EPSDT Demonstration Models***, the Health Services Research Institute developed demonstration models designed to assess the most cost-effective methods, techniques, and procedures for delivering EPSDT services in selected urban communities having high morbidity and mortality rates that correlate with high Medicaid-eligible population density. These demonstration projects were funded under Section 1115 in June 1975 for this purpose:

■ *EPSDT Demonstration in an Urban Setting (Dallas, Texas)*

This project is designed to provide insights into cost effective methods for case-finding and case monitoring, using a variety of alternative methods to stimulate parent responsiveness and to achieve high rates of child participation in the program. It will also develop and

demonstrate methods of case monitoring that will reflect high and cost effective rates of screen completions, problem completions, and rescreen completions for those children that had shown for screening. Methods to be tested include full-time case monitors of varying qualifications to determine the most effective and cost-beneficial combinations.

EPSDT Demonstration Program in Child Health (New York, New York)

This project, sponsored by the New York City Human Resources Administration, and subcontracted to the Medical and Health Research Association of New York City, will be conducted in five areas in South Bronx. The primary objectives of this project are: (a) to maximize the number of eligible children brought in for screening, and to determine the costs of different initial contact procedures; (b) to alter resources and means committed to case monitoring and determine differences in costs and case completion rates; (c) to modify the qualifications for personnel doing screening tests, and determine the varying costs and accuracy of screening tests, and determine the varying costs and accuracy of screening findings; and (d) to alter the resources and means committed to health care of children with health problems and identify outcomes. The project proposes to initiate an innovative effort in case findings, case monitoring, screening, diagnosis and treatment for about 30,000 children under six in the target area eligible for EPSDT services.

Evaluation of the Michigan EPSDT Program (Michigan Department of Social Services)

Sponsored by the Michigan Department of Social Services, and subcontracted to the University of Michigan School of Public Health, this project was designed to explore the feasibility and utility of a "tracer medical condition" method for assessing and improving the quality of care delivered through EPSDT programs. (A "tracer medical condition" is defined as one occurring with at least moderate frequency, on which there is reasonable consensus as to what constitutes quality care, and for which appropriate treatment produces clearly measurable outcomes.) The project will identify tracer medical conditions suitable for children, and develop a tracer assessment tool suitable for evaluating the quality of health care delivered to children.

Development of a Federal, State and Local Evaluation Model for EPSDT

Bokonon Systems developed a data classification system which they considered suitable for the evaluation needs of Federal, State and local EPSDT program managers. It plans to test this evaluation model in the following two sites:

Demonstration of a Statewide EPSDT Planning and Evaluation System (South Carolina Department of Social Services)

This project, to be implemented by the South Carolina Department of Social Services, will attempt to show how existing State health data systems can support EPSDT planning and evaluation needs for a Statewide EPSDT program; and develop and install a planning and evaluation system capable of producing necessary information on an on-going basis.

Utilizing Existing Health Data Systems to Demonstrate a Model for EPSDT Planning and Evaluation (Roosevelt Hospital, New York, N.Y.)

Sponsored by the New York State Department of Social Services and subcontracted to the Pediatric Service of Roosevelt Hospital, this project will attempt to show how existing health data systems can support the planning and evaluation needs of a local EPSDT program. Objectives include definition of planning and evaluation information requirements, development of data transformation and analysis packages, and training of staff to make effective use of available information.

Evaluation of a Developmental Screening and Diagnostic Test Battery (Roosevelt Hospital, New York, N.Y.)

The purpose of this project, involving 1,200 Medicaid-eligible children in the Pediatric Service at Roosevelt Hospital, is to develop a model for EPSDT developmental screening and diagnosis. It will test an innovative diagnostic battery, and will study the cost effectiveness and clinical validity of using paraprofessionals as data generators. It will also use computers to assist in data management and report generation. Since the Pediatric Service also provides treatment for identified medical problems, effort will be made to provide or arrange for appropriate treatment for developmental problems.

Rural Health Research and Demonstration Program

At the specific request of the Labor-HEW Subcommittee of the Senate Appropriations Committee, MSA/SRS is undertaking a program of research and demonstration projects in rural health

care delivery. The projects, to be monitored by Medical Services Administration, will provide primary medical care to Medicaid recipients and others. There is to be particular emphasis on maternal and child health services; early and periodic screening, diagnosis, and treatment of children; and pap smear testing and breast cancer detection for women.

The projects will test varying methods of (1) increasing the supply of physicians, physician assistants, and nurse practitioners; (2) making the medical services more accessible to rural residents; (3) increasing the local health system's ability to reduce (or limit) the medical needs of the community; and making more effective use of combinations of separate health programs through joint planning and coordination.

The following projects were funded effective July 1, 1975; the grants may be renewed up to a maximum of five years providing the projects demonstrate their ability to become self-sustaining:

Community Health Clinics, Inc., Nampa, Idaho; Prosser Memorial Hospital Prosser, Washington; Health Development Association of N.E. Kentucky, Morehead, Kentucky; Region II Health Planning Association, Inc., Huntington, West Virginia; Kennebec Valley Regional Health Agency, Waterville, Maine; Dartmouth-Hitchcock Medical Center, Hanover, New Hampshire; Glendive Community Hospital, Glendive, Montana; University of North Dakota Medical School, Drayton, North Dakota; Presbyterian Medical Services, Santa Fe, New Mexico

It is anticipated that 40 additional projects will be funded in the coming year. The program's objective is to develop new ways to provide medical care in critically underserved rural areas of the Nation.

Contracts

Technical Assistance to State and Local EPSDT Programs

The contract aims to provide technical assistance to State and local EPSDT programs to increase their effectiveness, both in meeting minimum standards established in relation to the penalty provision, and achieving State-established goals. A major thrust is to provide States with maximum help. Technical assistance is provided through the EPSDT division, and through a contractor, The Community Health Foundation, Evanston, Illinois, on an elective basis to nine States during the year.

Increased Professional Provider Participation in State and Local EPSDT Programs

The purpose of this contract with the American Academy of Pediatrics is to enlist increased interest, support, and effective participation of professional health care providers in the implementation of EPSDT. The contractor will establish liaison arrangements with representative of other national professional provider organizations and their State and local counterparts to inform them of program developments in EPSDT, to arrange for inclusion of EPSDT on the agenda of their meetings, to include reports on EPSDT in their professional journals, and in other ways to carry forward the recommendations of the American Medical Association's report on "Professional Provider Participation." The work is to be carried out through representatives designated in each of the 10 Regions.

Coordination of Volunteer Organizations and Agencies in Support of EPSDT

This contract is designed to enlist the interest, support, and appropriate resources of voluntary organizations and agencies in the effective implementation of EPSDT. The contractor, *National Council for Children and Youth*, will sponsor and chair a national advisory group to assist in arranging for more effective interagency collaboration with the private sector. It will develop an information brochure, a guide for voluntary agency involvement, and a model for local voluntary coordination. It will organize a national workshop around the best use of voluntary agency interest and support, and will provide consultant services on request to State and local voluntary organizations and agencies.

Professional Health Care Provider Collaboration in EPSDT at the Local Level

This project will explore alternative solutions to providing the assistance needed by professional health care providers attempting to meet EPSDT needs in private practice settings. It will develop a model whereby individual professional health care providers will be involved in a Community Health Services Program which draws upon existing resources and those that can be developed through a coordinated effort of all related community agencies and services including the schools, under the sponsorship of the local medical society.

As an outgrowth of the AMA's

Committee on Health Care of the Poor, the *Will-Grundy County Medical Society*, in Joliet, Illinois, initiated activities in April 1974 and continued through June 1975 in providing supportive services by developing and maintaining communication and coordination of various community agencies offering services to the Medicaid population; assigning patients to physicians, where needed, on a rotation basis; and assisting the school district in providing physical examinations, needed followup for diagnosis, and necessary treatment. These activities highlighted the difficulty private practitioners have in meeting needs of EPSDT-eligible children, and led to the recognition that the professional community itself must take a leadership role in developing accessibility to health care, even by encouraging nontraditional methods of health care delivery. This year's efforts are directed toward planning for an alternative solution to provide the supportive services needed by the professional health care provider in meeting EPSDT needs.

Developmental Assessment and Treatment under EPSDT

The American Orthopsychiatric Association is developing recommendations for consideration in planning for the implementation of the developmental assessment and treatment component of the EPSDT program.

A Guide to Diagnosis and Treatment under EPSDT

The American Academy of Pediatrics is developing a guide for the implementation of the diagnosis and treatment components of EPSDT as a sequel to the "Guide to Screening under EPSDT" developed previously by the AAP. This guide will also include practical recommendations for developing and managing an EPSDT program at the local level, including the full use of professional resources available in most communities to the EPSDT program.

A Training Guide for Social Service Workers in EPSDT

The University of Michigan is preparing materials for use by State and/or local training personnel of social service staff carrying EPSDT functions at the local level. Materials are designed for training staff, and for background use by local staff involved in EPSDT where no training staff is available. They are primarily addressed to the nonprofessional worker carrying out EPSDT functions.

A Model Program for Training Allied Health Professionals and Paraprofessionals to Perform Health Screening Services

The Health Facilities Foundation is developing materials that can assist EPSDT administrators, supervisors, and others in the training of allied health personnel in implementing EPSDT services. It reaches both clinic workers and private physicians' assistants.

The Older Child and Adolescent in EPSDT

An Inter-Agency Committee of the Bureau of Community Services of the Health Services Administration has prepared recommendations for dealing with the older child and adolescent in EPSDT. Since early program emphasis has been on the younger child, this material should be useful to State and local agencies in adapting their programs to reach such children and youth with needed help.

Assessment of EPSDT Practices and Costs

Applied Management Systems is gathering information in a sample number of States and localities on specific program components of EPSDT to evaluate and report on that information in such a way as to be useful on a short-term basis for management of the EPSDT program. It will highlight examples of good practice in EPSDT programs under various circumstances. It will also include an assessment of the effectiveness of various program arrangements that support case management to assure that followup steps are performed after screening; cost impact of EPSDT, and barriers to full EPSDT implementation.

Development of an EPSDT Model Management Information System

Consultec, Inc. is developing a general systems design incorporating an EPSDT system into the Medicaid Management Information System. This design will support program operations and functions at the State level, and provide statistical data and program information as required at Federal and State levels. Georgia has been selected as the model State for systems development and implementation planning purpose. The design produced will be flexible enough to apply to all State EPSDT programs.

Dr. Martz is a Medical Care Planning Specialist, EDSDT Division, Medical Services Administration, SRS.

Tax Credits for Employers of *WIN* Recipients

RICHARD FOGARTY

TWO CREDITS: A BOX SCORE

	Welfare tax credit	WIN tax credit
WHO		
Gets credit?	All private employers, including those who provide jobs for private household workers.	All private employers engaged in a trade or business.
Qualifies employers for credit?	AFDC recipients who have 90 continuous days of benefits.	AFDC recipients registered for WIN.
WHAT?	A credit equal to 20 percent of the wages and salaries paid in a tax year.	A credit equal to 20 percent of the wages and salaries paid for the first 12 months of employment.
WHY?	To help people on welfare move into jobs.	To help people on welfare move into jobs.
WHEN?	Now—and until July 1, 1976	Now—no expiration date.
WHERE?	Contact your local welfare office.	Get in touch with your local WIN office.
HOW MUCH?	Credit on all wages—with no upper limits on individual salaries or total amounts subject to credit except a cutoff of $5,000 on wages for each nonbusiness employee. Only restriction is a ceiling for *any one tax year* of $25,000 plus one-half of the amount over $25,000.	Credit on all wages—with no upper limits on individual salaries or total amounts subject to credit. Only restriction is a ceiling for *any one tax year* of $25,000 plus one-half of the amount over $25,000.

If you were a businessman who could save thousands of dollars in taxes by hiring competent welfare recipients, would you do it? If you could hire a gardener or domestic at home and *also* get a tax credit, would you do it?

The Departments of Labor and HEW are betting that you would. They are administering jointly the WIN (work incentive) program. In enacting the Tax Reduction Act of 1975, Congress laid the legislative base for a most significant manpower and social experiment—use of tax credit incentives to encourage employers to hire welfare recipients. This is known as the Federal Welfare Recipient Employment Incentive Tax Credit, or the Welfare Tax Credit.

Section 401 of the Tax Reduction Act of 1975 offers a dollar-for-dollar Federal Welfare Recipient Employment Incentive Tax Credit to private employers for providing jobs to individuals who at the time of hire are receiving financial assistance under the Aid to Families with Dependent Children (AFDC) Program of the Social Security Act. The credit is

equal to 20 percent of the gross wages paid during a tax year for services rendered by certain eligible employees.

This credit is a unique experiment in the United States and is effective for wages paid after March 29, 1975, and before July 1, 1976.

The new legislation defines an *eligible employee* as one who:

1. has been certified by a State or local welfare agency as being eligible for AFDC benefits and has been receiving such payments continuously for 90 days preceding the date of hire; and

2. has worked for the employer for 30 consecutive days or longer on a substantially full-time basis (or for at least three-quarters or more of the normal or customary work week;)

3. has not displaced any other individual from employment; and

4. is not a migrant worker. A migrant worker is a person for whom the customary period of employment by one employers is less than 30 days and whose employment requires that the individual travel from place to place once over a short period of time.)

Are domestics covered?

A tax credit also has been provided to private employers not engaged in a business or trade who hire AFDC recipients as domestics and other day workers and retain them for 30 days or longer. This credit is also equal to 20 percent of the gross wages paid an individual during a tax year but may not exceed $1,000 per employee.

What is the WIN Tax Credit?

The Federal Welfare Recipient Employment Incentive Tax Credit was not the first attempt by the Congress to provide a financial incentive for employers to hire certain groups of workers. Under the Revenue Act of 1971, employers can claim a tax credit for employing workers registered for the Work Incentive (WIN) Program.

Inasmuch as approximately only one-third of all adult AFDC recipients either volunteer or are required to enroll in the WIN program, the eligible population to be potentially served by the WIN credit is considerably smaller than that served by the more recently enacted welfare tax credit.

The WIN Tax Credit, like the welfare tax credit, is equal to 20 percent of the gross wages paid to or incurred by an eligible employee. However, there are more restrictions attached to the WIN credit than the newer welfare credit. For example, the WIN credit is limited to wages paid over the first 12 months of employment. While there is no length of employment time limit on the welfare tax credit it is available only until July 1, 1976. The 12-month credit period need not be consecutive, but may never extend beyond 24 months.

To claim the WIN Tax Credit, the employer must retain the WIN hire for 12 months beyond the 12-month credit period. This effectively assures 24 months of continued employment. Employers claiming the welfare tax credit need to retain the employee for only 30 days.

How much credit can be claimed?

The only limitation on the credits is a ceiling on the credits for any one tax year. The maximum for either is $25,000 plus one-half of the amount of taxes owed the Government in excess of $25,000. The law permits excess credits to be carried back 3 years and forward 7 years.

Let us take an example of a corporation with a *tax liability* in a given tax year of $50,000 and with accrued tax credits (under either the WIN or welfare tax credits) of $75,000.

Tax liability	$50,000
Maximum tax credit allowable is $25,000, plus 50% of one-half of the $50,000 (which is the balance of taxes owed, or $12,500	$37,500
Tax payable	$12,500

This company, as a result of the credits, is paying a tax of only 12,500. Without these credits, the company would have owed taxes of $50,000.

Not only does the employer reduce his taxes the first year, but he has an opportunity to "carry back" unclaimed credits the 3 previous years. In addition, the employer has a "carry forward" for the next seven years.

Who gets the credits?

If the employer is—

1. *An individual*—the individual taxpayer receives the tax credit.

2. *A corporation*—the corporation receives the credit against its income tax liability.

3. *A partnership*—the individuals comprising the partnership receive the credit.

4. *An electing small business corporation* which has elected that the shareholders are to be subject to the income tax. In this case, the shareholders are required to report the corporate income and will receive the tax credit.

5. *An estate or trust*—the estate or trust *or* the beneficiary, depending on the respective amounts of income allowable and thus taxable.

Are credits subject to rebate?

If an employer has reduced the income tax he owes through the credit allowable for wages paid a WIN employee and pays the WIN employee less than "comparable" wages (wages less than those received by someone else doing the same work), or if the employer terminates the employment without cause during the credit period or during the second year, the Internal Revenue Service has the right to recapture the tax credit. As to the Welfare Tax Credit, if an employer pays less than comparable wages to an employee, the employer will be required to rebate the credits claimed during the year in which such a violation occurs.

How will the plan be tested?

To test the effectiveness of financial incentives as a means of encouraging employers to hire AFDC recipients, the WIN national office has contracted with a private research and development firm to conduct demonstration projects in Minneapolis, Toledo, and Houston. An earlier study of the welfare tax credit disclosed limited employer usage of the WIN credit, mainly because of lack of knowledge about the credit. Objective of this demonstration project is to thoroughly "saturate" a community with information about the credit. Attempts will be made to disseminate the information and promote use of the credits through a major employer organization, the Metro Office of the National Alliance of Businessmen as well as through the media.

Projects will average between 4 and 8 months in duration. During that time project staff will survey employers to determine their reactions to the tax credit and the extent use or non use.

Results in each of the three demonstrations sites will be compared with three other cities, Milwaukee, Cincinnati and San Antonio. They will be "matched" by selected characteristics, to determine the impact of the additional information provided to the demonstration areas.

Results of the demonstration projects, along with data collected through an intensive survey of welfare and WIN records in 150 cities throughout the country will provide the WIN national office with comprehensive national data on the extent of use of both credits, employer perceptions of the credits and opinions toward them, industries and occupations in which the new workers are located, and some measures of welfare savings.

Findings from both the demonstration and research projects will provide major bases for recommendations to the Congress concerning further legislative action regarding financial incentives.

How much can be saved?

Let us assume a corporate employer has two employees; one, an AFDC recipient covered by the tax credits, the other, a regular employee. Each employee is paid $10,000 over the course of a tax year. Let us also assume that a corporation pays a regular tax of 22 percent, and a surtax of 26 percent for a total of 48 percent.

	Regular Employee	*AFDC or WIN Employee Covered By Credits*
Corporation pays wages	$10,000	$10,000
Corporation benefits, taxwise:		
Normal tax	2200	2200
Surtax	2600	2600
Credit against the tax	0	2000
Total Tax Benefits	4800	6800
Net cost to employer, wage payment, less tax saving	5200	3200

Based on experience with these credits, Congress will determine sometime this year whether to

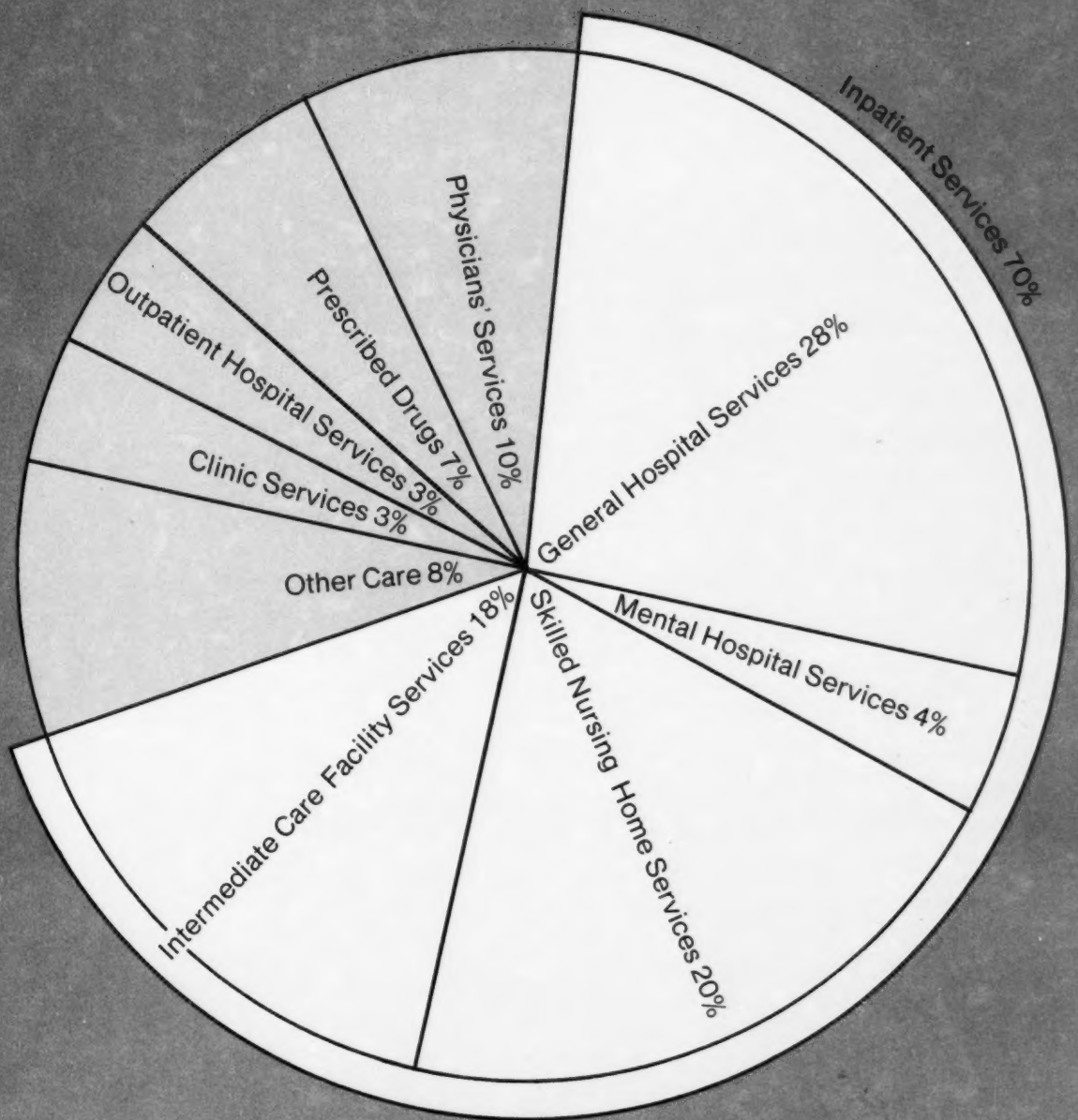
- repeal the credits
- extend the same credits
- expand the program

Meanwhile, a potential saving can be realized by private employers who know and take advantage of this program.

Promises of the new program include more dollars to the employer and a reduction in the welfare rolls with its subsequent savings to the taxpayer. But the greatest benefit of all will be the improvement of life for those welfare recipients who get jobs as a result of the new tax incentives.

Mr. Fogarty is a Manpower Development Specialist, Manpower Administration, U.S. Department of Labor.

Percent Distribution of Medicaid Dollars
by type of service fiscal year 1975



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